

**Post-traumatic Neurosis**

**Q.**—*I have a patient, a young man, who as a result of a trivial injury to his finger has sustained a severe and progressive post-traumatic neurosis, resulting in paralysis of the same arm and leg and rigidity of neck and spine. This condition has now been present for three years. I have been told that a satisfactory settlement of his claim for compensation will result in complete restoration of function. I disagree. What does your expert think ?*

**A.**—Where the disability is due to hysteria (purposive functional incapacity) alone, settlement may lead to restoration of function, but the process may take time, and rehabilitation measures will be necessary. More often the patient has to be given a period of light work while he recovers from the effects of his period of idleness and of the invalid attitude which has accompanied his symptoms. If the patient is of low intelligence, has a poor work record, or is not really capable by reason of age, fear, or other factors of doing his former job, the course of his illness is not much affected by settlement. Where injury is trivial, the neurosis is due more to the patient's inability to adapt himself to his work than to the injury and resulting claim. Only where his lawyer or compensation secretary have, in their enthusiasm, implied that the patient would be letting them down by recovering, and where very superficial self-deception or malingering are suspected, can full recovery be predicted with confidence.

It is important to remember that organic nervous disease not infrequently makes its appearance in the guise of a traumatic neurosis after trivial injury, and this must be carefully excluded if the disability progresses or if it has a hemiplegic distribution. Settlement will here improve neither the organic nor the functional component. Organic disease apart, the prognosis depends on the patient's personality, and it is unusual for a patient of sound personality to maintain symptoms for three years. Compensation may not be the most important aetiological factor.

**Estimating the E.S.R.**

**Q.**—*What is the best way of taking and preserving blood for E.S.R. estimation in general practice ? Please indicate any special precautions necessary for an accurate result.*

**A.**—In general, sodium citrate is to be preferred to oxalate as an anticoagulant, because when oxalate is used the normal range is up to 20 mm. for healthy males and is higher in women, whereas with the Westergren citrate technique, with a 200-mm. tube, the upper limit of normal for healthy males may be considered as 4 mm. and in females up to 8 mm. In my experience a 200-mm Westergren tube and the use of sodium citrate as an anticoagulant is more satisfactory than the Wintrobe technique.

Almost any stand which will hold the tubes vertical may be used. The apparatus should be kept at an approximately constant temperature, because sedimentation depends on temperature. It is also desirable to set up the test as soon as possible after collecting the blood, because, if the blood is kept, aggregation of the cells may occur and the sedimentation rate may be falsely high.

**Laboratory Investigations in Periarthritis Nodosa**

**Q.**—*What laboratory investigations are helpful in the diagnosis of periarthritis nodosa ? Are there any changes in the plasma proteins ?*

**A.**—Most patients with periarthritis nodosa show anaemia and a leucocytosis of 10,000–25,000 with a left shift. Albuminuria, haematuria, and cylinduria occur in about two-thirds and eosinophilia in about one-third of all cases, the last almost exclusively among those with asthma. False positive Wassermann reactions and increased serum globulin are found in about half. Hyposthenuria and nitrogen retention occur in many cases, but usually in the terminal phases only. No detailed studies on the serum proteins have so far been published. The diagnosis of periarthritis

nodosa during life can be made only when it has been suspected on clinical grounds ; and the most effective method of confirmation is by muscle biopsy.

**NOTES AND COMMENTS**

**Food Value of Ice-cream.**—Dr. D. LIVINGSTONE (Leamington Spa) writes: With reference to your question and answer on ice-cream ("Any Questions?" May 23, p. 1177) reference might well have been made to the legal minimum standards laid down by Statutory Instrument No. 828 of 1953, The Food Standards (Ice-Cream) Order, which came into force on June 1.

[*N.B.*—This Instrument lays it down that ice-cream (but not water ices or ice lollies) shall contain not less than 5% fat, 10% sugar, and 7½% milk solids other than fat. Alternative standards are provided for fruit-containing ice-cream and kosher ices.]

**Treatment of Homosexual Tendencies.**—Dr. CLIFFORD ALLEN (London, W.1) writes: I was surprised to read in "Any Questions?" (May 30, p. 1234) the assertion that it may be necessary to use narco-analysis to discover whether a homosexual patient is likely to respond to therapy. This is really an astonishing suggestion. I have never found narco-analysis necessary either to discover the prognosis or in the actual treatment of paraphiliacs. I am not averse to using narco-analysis in other suitable cases, but I cannot conceive how it can be of value in homosexuality. Rees long ago gave a number of factors upon which he thought prognosis should be based. These were age, duration of symptoms, intelligence, desire for cure, and social situation. I should like to add a number of others, which are: whether the patient has built up a homosexual environment and surrounded himself with abnormal friends; how much overt sexuality has developed or whether he merely has urges and fantasies; if the homosexuality is associated with alcoholism (when both are more difficult to treat). The ability to afford private treatment is also of importance, since it is very difficult to devote enough time to a patient of this type in an out-patient department. I have never heard of a case which was cured in prison in spite of the judge's invariable assurance when he sentences offenders that they will be treated adequately during their imprisonment. The essence of treatment is to unearth and dig away the emotional attachments and prohibitions which prevent normal development and then to encourage the patient to widen the environment into a normal sexual one. Many homosexuals are afraid of women and, once this fear is removed, will rapidly advance to normality. The will to recover is, perhaps, the most important factor, and without it nothing can be done. The oldest patient I have succeeded in curing was over 40, but it is much easier in youth.

OUR EXPERT writes: If Dr. Allen will consult my answer again, he will see that narco-analysis was not recommended as the ideal method of treatment in all cases of psychosexual inversion. The suggestion was that many psychiatrists may be able to obtain strong indications from one or two narco-exploratory sessions as to the likelihood of systematic analytical psychotherapy being able to bring about a reorientation of the sexual impulse. There is, by implication, the further suggestion that, however carefully the history may be taken, no other technique, if narco-analysis is skilfully employed, can provide so much valuable, relevant information with such economy of time.

**Correction.**—Dr. P. J. Fraser's communication on succinylmonocholine, mentioned in the letter of Dr. H. O. J. Collier and Miss Barbara Macauley (*Journal*, June 6, p. 1279), was made to the British Pharmacological Society, not to the British Pharmaceutical Society.

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